

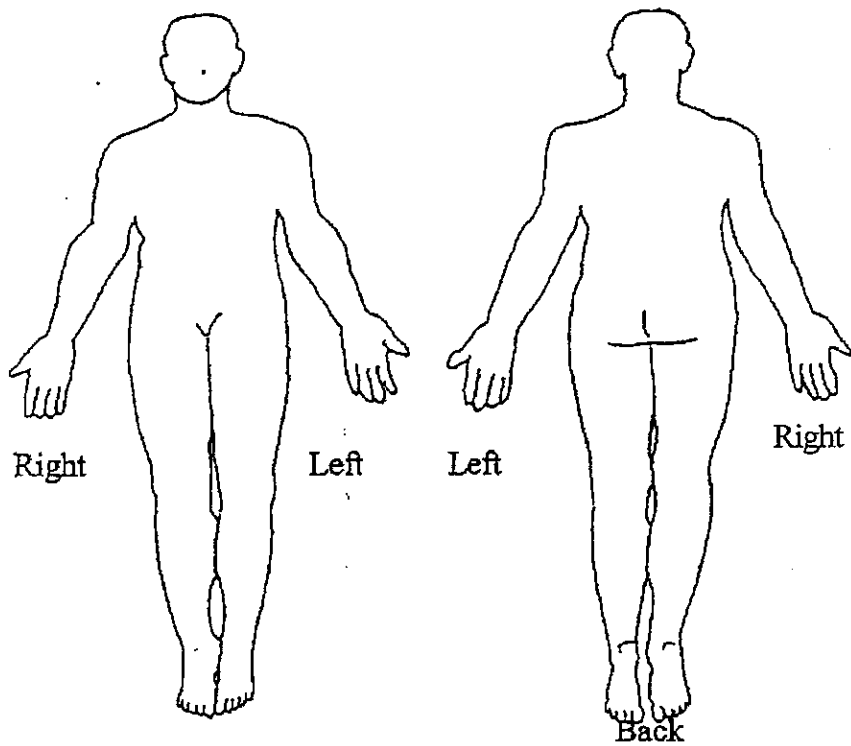
PAIN DIAGRAM - FOLLOW-UP

Name _____ Age _____ Gender M/F Date _____

Height _____ Weight _____ Date of Injury _____

Please mark the areas where you experience the following sensations:

Ache AAA Numbness NNN Pins & Needles PPP Burning BBB Stabbing SSS



What medications are you taking for pain?

Do you need refills Yes / No ?

Since your last office visit are you: Better Worse The same? Please circle your answer.

How bad is your pain? Place an "X" (X) on each of the lines below to indicate your current pain.

How bad is your low back pain?

No pain _____ Worst possible

How bad is your leg pain?

No pain _____ Worst possible

How bad is your middle back pain?

No pain _____ Worst possible

How bad is your neck pain?

No pain _____ Worst possible

How bad is your arm pain?

No pain _____ Worst possible